STRONG HEALTH
STRONG MEMORIAL HOSPITAL

ADULT NEUROLOGY NEW PATIENT/ CONSULTATION NOTE

SMH 181A MR
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☐ Inpatient
☐ Outpatient
☐ ED

[redacted]

Patient Name: ____________________
Unit #: ____________ DOB: ____________

Date: 10/26/10 **Time:** 17 20

Referring Physician: Dr [redacted] ED Attending

Chief Complaint:

headache x 5 days

History of Present Illness: (location, quality, severity, duration, timing, context, modifying factors, associated signs & symptoms)

Pt is a 25 y/o ♂ who was in USOH and experienced a dull headache beginning [illegible] Friday morning 10/22. He describes it as dull, intermittently throbbing, present at all times, (R) fronto-temporal & retro-orbital pain. Initially he rated it 4/10. It escalated throughout the weekend and greatly worsened on Monday am → 7/10. It started to have intermittent sharp, shooting quality to it as well. He denies any nausea, vomiting, dizziness, somnolence or difficulty in arousing him. Denies any blurry vision, double vision. Denies any numbness, weakness in his limbs. Denies any focal neurologic symptoms. He himself does not have a history of headaches but his mother has migraines. He denies any fevers, chills, sweats, weight loss. Has developed photophobia the last few days. Also has had some [illegible] last 2 days but no frank [illegible] at home

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Past Medical/Surgical History:

Allergies/Sensitivities: ☐ Yes ☒ No If Yes, list with reactions

Latex Allergy. ☐ Yes ☐ No If Yes, describe

Social History:

Works [redacted]

Alcohol Tobacco Recreational Drugs

Family History:

Medications/Over-The-Counter/Vitamins/Herbals:

Name	

Review of Systems: (Check box if negative)

General:	☒	**GI/Nutritional Status:**	☒
Head:	☐	**GU:**	☒
ENT:	☒	**Skin:**	☐
Cardiovascular:	☒	**Psychiatric:**	☒
Respiratory:	☒	**Endocrine:**	☐
Musculoskeletal:	☒	**Hematologic:**	☒
Pain	☒ Circle one Range 0 1 2 3 4 5 6 7 8 9 10 highest	Location	
Abuse	☒ Is there anyone at home or elsewhere who is hurting you?		

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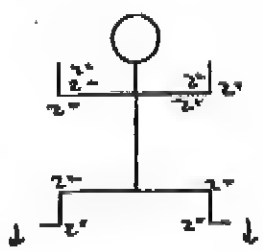
BP = 134/72	P = 76	RR = 16	T = 37°	*(must do 3 of 4)
*General appearance				
*Heart		Lungs		
*Carotids		*Penpheral pulses		
Spine				
Neurological exam:				
Mental status:				
*Attention		Neglect		
*Language				
*Orientation				
*Memory				
*Intellect, fund of knowledge, judgment, mood and affect thought content.				
Cranial Nerve: *Visual Acuity		*V		
Visual Field		*VII		
*Fundi		*VIII		
Pupils		*IX, X		
*EOM's		*XI		
		*XII		
Motor: Bulk				
*Tone				
Pronator drift				
*Strength				
Abnormal movements				
*Sensory: Pin and temperature				
Vibration and position				
Cortico-sensory				
Romberg				
*Coordination:				
*Gait:				

*Reflexes:



1a LOC		3 Visual fields		7 Right leg motor		11 Best language	
1b LOC questions		4 Facial paresis		8 Left leg motor		12 Dysarthria	
1c LOC commands		5 Right arm motor		9 Limb ataxia		13 Neglect	
2 Best gaze		6 Left arm motor		10 Sensory		Total	

Release signs

[redacted]

Patient Name [redacted]

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Laboratory:

Chem 2 140 | 103 | 28 / 99 Ca 9.5
4.5 | 25 | 0.96

Radiology:

CT w/o contrast: (R) ventricle dilatation, cannot rule out mass process but "most likely related to old insult."

Impression:

This is a case of new onset HA in a 25 year old male c̄ no significant PMHx and CT evidence of (R) [illegible] hydrocephalus. DDx for this process includes congenital atresia of foramen of Monro, subependymal giant cell astrocytoma, [illegible], colloid cysts, choroid plexus papilloma. Given the relatively rapid onset and progression of symptoms, despite his reassuringly normal exam, concern is for a more acute process and [illegible] due to increased ICP. They may also request [illegible] as follows:

Plan:

- Will review with attending Dr. [illegible]
- Neurosurgery consult as needed [illegible] appropriate

[redacted]

- MRI head to further evaluate cause of potential blockage of Foramen of Monro

Signature: [redacted] **Date:** 10/26/10

I saw and evaluated the patient I reviewed the resident's notes and agree I note my addendum below or on form SH 402

25-yo man c̄ no prior headache history presenting c̄ several days of progressively intensifying new HA. Sensitive to lights + sounds. No nausea, diplopia, or other neuro sx. On exam, pupils equal + reactive, optic disc margins sharp, ocular movements normal, (R) Babinski sign present. CT head shows enlargement of (R) lateral ventricle c̄ midline shift. ? hypervascularity of [illegible] in the area of [illegible] (R) thalamus. No definite lesion in (R) Foramen of Monro. 3rd vent. [illegible] + 4th vent nl.

Attending Signature: **Date:**

HPI	ROS	Exam	Complexity	Inpt Attg Code	Inpt Consult Code	Outp Consult Code
1-3	N/A	1-5	Straightforward	--	51	41
1-3	1	6-11	Straightforward	--	52	42
4	2-9	12-22	Low	21	53	43
4	10	All 23	Moderate	22	54	44
4	10	All 23	High	23	55	45

Day of Discharge Code 38 or 39 Imp. new onset headaches c̄ CT findings suspicious for obstructive (R) ventricular enlargement. Recommend — MRI w/+ contrast tomorrow (allow CT contrast to washout — reg completed) Q4° neuro checks. Analgesia. Page me directly c̄ questions or concerns

[redacted]